DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:	David Edwards, RPN	Chairperson
	Sylvia Douglas	Public Member
	Carly Gilchrist, RPN	Member
	Lalitha Poonasamy	Public Member
	Desiree-Ann Prillo, RPN	Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO	)	GLYNNIS HAWE for
	)	College of Nurses of Ontario
- and -	)	
	)	
HAMDI FARAH	)	GRANT W. FERGUSON for
Registration No. JD06967	)	Hamdi Farah
	)	
	)	CHRISTOPHER WIRTH
	)	Independent Legal Counsel
	)	
	)	Heard: July 10, 2020

DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee (the "Panel") of the College of Nurses of Ontario (the "College") on July 10, 2020, via videoconference.

Publication Ban

College Counsel brought a motion pursuant to s.45(3) of the *Health Professions Procedural Code* of the *Nursing Act, 1991*, for an order preventing public disclosure and banning publication or broadcasting of the identities of the patients, or any information that could disclose the identities of the patients, referred to orally or in any documents presented in the Discipline hearing of Hamdi Farah.

The Panel considered the submissions of the parties and decided that there be an order preventing public disclosure and banning publication or broadcasting of the identities of the patients, or any information that could disclose the identities of the patients, referred to orally or in any documents presented in the Discipline hearing of Hamdi Farah.

The Allegations

College Counsel advised the Panel that the College was requesting leave to withdraw the allegations set out in paragraphs 2(a), 2(b) and 2(d) of the Notice of Hearing dated June 8, 2020. The Panel granted this request. The remaining allegations against Hamdi Farah (the "Member") are as follows:

IT IS ALLEGED THAT:

1. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Nursing Act, 1991*, S.O. 1991, c. 32, as amended, and defined in subsection 1(1) of *Ontario Regulation 799/93*, in that on or about December 25, 2016, while employed as a Registered Practical Nurse ("RPN") at Villa Leonardo Gambin (the "Facility"), you contravened a standard of practice of the profession or failed to meet the standards of practice of the profession with respect to the following incidents:

    (a) you failed to assess and/or reassess, and/or inadequately documented your assessment and/or reassessment, of [the Patient]'s need for restraint;

    (b) you failed to consider and/or inadequately documented your consideration of available alternatives to restraints before applying a restraint to [the Patient];

    (c) you restrained [the Patient] when it was not necessary to do so and/or used a restraint that was not the least restraint required to meet [the Patient']s needs;

    (d) you used an improper device to restrain [the Patient];

    (e) you failed to document the application of a restraint to [the Patient];

    (f) you failed to obtain a physician's order for the application of a restraint prior to or following the application of a restraint to [the Patient];

    (g) you failed to obtain the consent of [the Patient] or her substitute decision-maker regarding the application of a restraint;

    (h) you failed to notify [the Patient] or her substitute decision-maker of the reason for the application of a restraint; and/or

    (i) you failed to monitor [the Patient] and/or inadequately documented your monitoring of [the Patient] at appropriate intervals while she was restrained;

2. You have committed an act of professional misconduct, as provided by subsection 51 (1)(c) of the *Health Professions Procedural Code* of the *Nursing Act, 1991, S.O. 1991, c. 32*, as amended, and defined in paragraph 1(13) of *Ontario Regulation 799/93*, in that, on or about December 25, 2016, while practicing as a RPN at the Facility, you failed to keep records as required, with respect to the following incidents:

    (a) [*Withdrawn*];

(b) [*Withdrawn*];

(c) you failed to document the application of a restraint to [the Patient]; and/or

(d) [*Withdrawn*]; and/or

3. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Nursing Act, 1991, S.O. 1991, c. 32*, as amended, and defined in subsection 1(37) of *Ontario Regulation 799/93*, in that, on or about December 25, 2016, while practicing as an RPN at the Facility, you engaged in conduct that would reasonably be regarded by members as disgraceful, dishonourable or unprofessional, with respect to the following incidents:

   (a) you failed to assess and/or reassess, and/or inadequately documented your assessment and/or reassessment, of [the Patient]'s need for restraint;

   (b) you failed to consider and/or inadequately documented your consideration of available alternatives to restraints before applying a restraint to [the Patient];

   (c) you restrained [the Patient] when it was not necessary to do so and/or used a restraint that was not the least restraint required to meet [the Patient]'s needs;

   (d) you used an improper device to restrain [the Patient];

   (e) you failed to document the application of a restraint to [the Patient];

   (f) you failed to obtain a physician's order for the application of a restraint prior to or following the application of a restraint to [the Patient];

   (g) you failed to obtain the consent of [the Patient] or her substitute decision-maker regarding the application of a restraint;

   (h) you failed to notify [the Patient] or her substitute decision-maker of the reason for the application of a restraint; and/or

   (i) you failed to monitor [the Patient] and/or inadequately documented your monitoring of [the Patient] at appropriate intervals while she was restrained.

Member's Plea

The Member admitted the allegations set out in paragraphs 1(a), 1(b), 1(c), 1(d), 1(e), 1(f), 1(g), 1(h), 1(i), 2(c) and 3(a), 3(b), 3(c), 3(d), 3(e), 3(f), 3(g), 3(h), 3(i) in the Notice of Hearing. The Panel received a written plea inquiry which was signed by the Member. The Panel also conducted an oral plea inquiry and was satisfied that the Member's admission was voluntary, informed and unequivocal.

Agreed Statement of Facts

College Counsel and the Member's Counsel advised the Panel that agreement had been reached on the facts and introduced an Agreed Statement of Facts, which reads, unedited, as follows:

THE MEMBER

1. Hamdi Farah (the "Member") obtained a diploma in nursing from George Brown College in 2004.

2. The Member registered with the College of Nurses of Ontario ("CNO") as a Registered Practical Nurse ("RPN") on November 4, 2004.

3. The Member was employed at Villa Leonardo Gambin (the "Facility") from November 30, 2004 until January 11, 2017, when her employment was terminated following the incident described below.

THE FACILITY

4. The Facility is a long-term care home located in Woodbridge, Ontario.

5. The Member worked as the fifth floor Charge Nurse, which has 28 patients. The Member was the only registered staff member on the floor during her shifts and was responsible for supervising three other staff members on shift, who were personal support workers ("PSWs").

THE PATIENT

6. [ ] (the "Patient") was 92 years old at the time of the incident and a longstanding resident of the Facility. [The Patient] was visually impaired and diagnosed with dementia and early Parkinson's, among other comorbidities.

7. [The Patient] had suffered falls prior to the date of the incident, and had been in the Facility's "fall prevention program" since at least mid-2016.

INCIDENTS RELEVANT TO ALLEGATIONS OF PROFESSIONAL MISCONDUCT

8. In the evening of December 25, 2016, [the Patient] was seated in a wheelchair in front of the nursing station on the fifth floor of the Facility.

9. Between 6:00 pm and 6:45 pm, [the Patient] repeatedly unbuckled the wheelchair's lap belt, sat forward in the wheelchair, and occasionally stood, before sitting back down in the wheelchair. During that time, multiple PSWs directed [the Patient] to sit down in the wheelchair and re-buckled the lap belt over [the Patient]'s lap.

10. Around 6:45 pm, the Member and a PSW approached [the Patient] while she was seated in the wheelchair. The Member instructed [the Patient] to briefly stand. As seen in the Facility's video surveillance footage, [the Patient] appeared unstable while standing.

11. The PSW repositioned [the Patient] in the wheelchair and fastened the wheelchair's lap belt over [the Patient]'s lap. The Member then placed a bedsheet over the lap belt and tucked it loosely behind [the Patient]'s back. The Member pulled [the Patient]'s shirt down to cover the bedsheet and the lap belt.

12. Immediately afterwards, [the Patient] untucked the bedsheet from around her waist and unbuckled the wheelchair's lap belt.

13. Around 6:50 pm, with the assistance of another PSW, the Member repositioned [the Patient] in her wheelchair and buckled the lap belt over her lap. The Member then drew the bedsheet around [the Patient]'s waist, covering the lap belt, and tied the sheet around the back of the wheelchair, restraining [the Patient] in the wheelchair.

14. Around 6:57 pm, the Member left the nursing station for her break. The Member did not return until around 8:13 pm.

15. [The Patient] remained restrained in her wheelchair by the bedsheet until around 8:02 pm, when the Facility's Associate Director of Care discovered [the Patient] and ordered a PSW to remove the bedsheet.

16. If the Member were to testify, the Member would say that she restrained [the Patient] with the bedsheet because she was concerned for [the Patient]'s safety and felt she was at imminent risk of falling. The Member would also say that she intended for the bedsheet to be in place for only a few minutes, and that before the Member left on her break, she had instructed a PSW to remove the bedsheets as soon as she was finished with another task.

17. However, the Member admits the following:

    - she did not conduct a falls assessment,
    - she did not consider or trial alternative restraints,
    - she did not document applying a restraint to [the Patient],
    - she did not monitor or reassess [the Patient] at any time after applying the restraint,
    - she did not obtain a physician's order for the restraint, and
    - she neither sought the consent of either [the Patient] or [the Patient]'s substitute decision-maker to apply the restraint, nor did she tell [the Patient]'s substitute decision-maker that a restraint had been applied.

18. The Member also admits that bedsheets are not an appropriate restraint device and were not the least restraint required to meet [the Patient]'s needs in the circumstances.

HOSPITAL POLICIES

Restraint Implementation Protocols

19. The Hospital's *Restraint Implementation Protocols* is a least restraints policy, which requires that if a patient needs a restraining device, the least restrictive device will be used for the least amount of time.

20. The *Restraint Implementation Protocols* requires that if a nurse identifies a patient who is at high risk of injury to him or herself and requires a restraint, the nurse will:

    - document the rationale and notify the family;
    - monitor the patient's condition every 15 minutes; and
    - obtain and document a physician or nurse practitioner's order within 12 hours of the restraint application.

21. The Restraint Policy requires that the nurse document his/her rationale for applying restraints, monitor a patient's condition at least every 15 minutes while restraints are in use, and acquire a physician's order within 12 hours of the restraint application to a patient.

CNO STANDARDS

22. CNO has published nursing standards to set out the expectations for the practice of nursing. CNO's standards inform nurses of their accountabilities and apply to all nurses regardless of their role, job description, or area of practice.

Professional Standards

23. CNO's *Professional Standards* provides that each nurse is accountable to the public and responsible for ensuring that her practice and conduct meets legislative requirements and the standard of the profession.

24. A nurse demonstrates this standard by actions such as:

    - providing, facilitating, advocating and promoting the best possible care for patients;
    - assessing/describing the patient situation using a theory, framework or evidence-based tool and identifying/recognizing abnormal or unexpected client responses and acting appropriately;
    - advocating on behalf of patients;
    - seeking assistance appropriately and in a timely manner;
    - taking action in situations in which patient safety and well-being are compromised; and
    - ensuring practice is consistent with CNO's standards of practice and guidelines as well as legislation.

Therapeutic Nurse-Client Relationship Standard

25. CNO's *Therapeutic Nurse-Client Relationship Standard* ("TNCR Standard") provides guidance to nurses on establishing and maintaining appropriate relationships with patients. The TNCR Standards notes that the therapeutic relationship with patients is at the core of the practice of nursing.

26. The TNCR Standard places the responsibility for establishing and maintaining the therapeutic nurse-patient relationship on the nurse. Therapeutic nursing services "contribute to the [patient's] health and well-being" and the relationship is based on "trust, respect, empathy and professional intimacy, and requires the appropriate use of power inherent in the care provider's role."

27. The TNCR Standard specifies that nurses meet the standard for patient-centred care by working with the patient to ensure that all professional behaviours and actions meet the therapeutic needs of the patient. A nurse meets the standard by:

    - actively including the patient as a partner in care because the patient is the expert on his/her life;
    - gaining an understanding of the patient's abilities, limitations and needs related to his/her health condition and the patient's needs for nursing care or services;
    - recognizing that the patient's well-being is affected by the nurse's ability to effectively establish and maintain a therapeutic relationship; and
    - engaging the patient in evaluating the nursing care and services that the patient is receiving.

Decisions About Procedures and Authority Standard

28. CNO's *Decisions About Procedures and Authority Standard* outlines the expectations of nurses when determining if they have the authority to perform a procedure, when it is appropriate to perform a particular procedure and are they competent to perform the procedure.

29. The Standard recognizes that making decisions, regardless of the practice setting, can have serious ramifications for patient safety.

30. There are accountabilities for nurses in all practice settings, including whether an action is a controlled act authorized to nursing, requires delegation or an order, can be initiated within certain contexts and is in the nurse's range of skills and training to be performed.

Documentation Standard

31. CNO's *Documentation Standard* provides that nurses are accountable for ensuring their documentation of client care is "accurate, timely and complete." The standard further clarifies that a nurse meets the standard by:

- ensuring documentation is a complete record of nursing care provided and reflects all aspects of the nursing process, including assessment, planning, intervention (independent and collaborative) and evaluation;
- documenting in a timely manner and completing documentation during, or as soon as possible after, the care or event; and
- ensuring that relevant client care information is captured in a permanent record.

ADMISSIONS OF PROFESSIONAL MISCONDUCT

32. The Member admits that she committed the acts of professional misconduct as alleged in paragraphs 1(a)-(i) of the Notice of Hearing, as described in paragraphs 8-18 above, in that she breached the standards of practice.

33. The Member admits that she committed the acts of professional misconduct as alleged in paragraph 2(c) of the Notice of Hearing, as described in paragraphs 8-18 above, in that she failed to keep records as required.

34. The Member admits that she committed the acts of professional misconduct as alleged in paragraphs 3(a)-(i) of the Notice of Hearing, as described in paragraphs 8-18 above, in that her conduct was disgraceful, dishonourable and unprofessional.

35. With leave of the Discipline Committee, CNO withdraws the following allegations in the Notice of Hearing:

- 2(a);
- 2(b); and
- 2(d).

Decision

The College bears the onus of proving the allegations in accordance with the standard of proof, that being the balance of probabilities based upon clear, cogent and convincing evidence.

Having considered the evidence and the onus and standard of proof, the Panel finds that the Member committed acts of professional misconduct as alleged in paragraphs 1(a), (b), (c), (d), (e), (f), (g), (h),

(i) and 2(c) of the Notice of Hearing. As to allegation 3(a), (b), (c), (d), (e), (f), (g), (h), (i), the Panel finds that the Member engaged in conduct that would reasonably be considered by members to be disgraceful, dishonourable and unprofessional.

Reasons for Decision

The Panel considered the Agreed Statement of Facts and the Member's plea and finds that this evidence supports findings of professional misconduct as alleged in the Notice of Hearing.

Allegation #1(a) in the Notice of Hearing is supported by paragraphs 8-32 in the Agreed Statement of Facts. The Member admits to this allegation and admits that she did not conduct a falls assessment. The Member did not document the application of a restraint, nor did she monitor or reassess the patient at any time after applying the restraint.

Allegation #1(b) in the Notice of Hearing is supported by paragraphs 8-32 in the Agreed Statement of Facts. The Member admits to this allegation in that she failed to document, consider or trial any other restraints for the patient.

Allegation #1(c) in the Notice of Hearing is supported by paragraphs 8-32 in the Agreed Statement of Facts. The Member admits to this allegation and also admits that bedsheets are not an appropriate restraint device and were not the least restraint required to meet the patient's needs in the circumstances.

Allegation #1(d) in the Notice of Hearing is supported by paragraphs 8-32 in the Agreed Statement of Facts. The Member admits to this allegation and also admits that bedsheets are not an appropriate restraint device to meet the needs of the patient.

Allegation #1(e) in the Notice of Hearing is supported by paragraphs 8-32 in the Agreed Statement of Facts. The Member admits to this allegation in that she failed to document the application of the restraint to the patient.

Allegation #1(f) in the Notice of Hearing is supported by paragraphs 8-32 in the Agreed Statement of Facts. The Member admits that she did not obtain a physician order for the application of the restraint.

Allegations #1(g) and #1(h) in the Notice of Hearing are supported by paragraphs 8-32 in the Agreed Statement of Facts. The Member admits to this allegation and that she neither sought the consent of either the patient's substitute decision-maker to apply the restraint, nor did she tell the patient's substitute decision-maker that a restraint had been applied.

Allegation #1(i) in the Notice of Hearing is supported by paragraphs 8-32 in the Agreed Statement of Facts. The Member admits to this allegation in that she failed to monitor and adequately document the monitoring of the patient at appropriate intervals. According to the Restraint Implementation Policy the patient's condition is to be monitored every 15 minutes while restraints are in use.

Allegation #2(c) in the Notice of Hearing is supported by paragraphs 8-18, 31 and 33 in the Agreed Statement of Facts. The Member admits that she did not document the application of the restraint to the

patient. The College's *Documentation Standard* indicates that the nurse must ensure documentation is a complete record of nursing care provided and is completed in a timely manner, during or as soon as possible after the care or an event.

With respect to Allegations # 3(a), (b), (c), (d), (e), (f), (g), (h) and (i), the Panel finds that the Member's conduct in failing to maintain appropriate documentation was unprofessional as it demonstrated a serious and persistent disregard for her professional obligations. The Panel also finds that the Member's conduct was dishonourable as the Member knew or ought to have known that her conduct through her continual disregard for her professional obligations and by failing to restrain a patient in a safe and appropriate manner was unacceptable and fell below the standards of a professional. Finally, the Panel finds that the Member's conduct was disgraceful as it shames the Member and by extension the profession. The conduct casts serious doubt on the Member's moral fitness and inherent ability to discharge the higher obligations the public expects professionals to meet.

Penalty

College Counsel and the Member's Counsel advised the Panel that a Joint Submission on Order had been agreed upon. The Joint Submission on Order requests that this Panel make an order as follows:

1. Requiring the Member to appear before the Panel to be reprimanded within three months of the date that this Order becomes final.

2. Directing the Executive Director to suspend the Member's certificate of registration for two months. This two-month suspension shall take effect from August 10, 2020 and shall continue to run without interruption as long as the Member remains in the practising class.

3. Directing the Executive Director to impose the following terms, conditions and limitations on the Member's certificate of registration:

    a) The Member will attend a minimum of two meetings with a Regulatory Expert (the "Expert") at her own expense and within six months from the date that this Order becomes final. If the Expert determines that a greater number of session are required, the Expert will advise the Director of Professional Conduct (the "Director") regarding the total number of sessions that are required and the length of time required to complete the additional sessions, but in any event, all sessions shall be completed within 12 months from the date that this Order becomes final. To comply, the Member is required to ensure that:

        i. The Expert has expertise in nursing regulation and has been approved by the Director of Professional Conduct (the "Director") in advance of the meetings;

        ii. At least seven days before the first meeting, the Member provides the Expert with a copy of:

1. the Panel's Order,
2. the Notice of Hearing,
3. the Agreed Statement of Facts,
4. this Joint Submission on Order, and
5. if available, a copy of the Panel's Decision and Reasons;

iii. Before the first meeting, the Member reviews the following CNO publications and completes the associated Reflective Questionnaires, online learning modules, decision tools and online participation forms (where applicable):

1. *Professional Standards*,
2. *Code of Conduct*,
3. *Therapeutic Nurse-Patient Relationship*, and
4. *Decisions about Procedure and Authority*;

iv. At least seven days before the first meeting, the Member provides the Expert with a copy of the completed Reflective Questionnaires and online participation forms;

v. The subject of the sessions with the Expert will include:

1. the acts or omissions for which the Member was found to have committed professional misconduct,
2. the potential consequences of the misconduct to the Member's patients, colleagues, profession and self,
3. strategies for preventing the misconduct from recurring,
4. the publications, questionnaires and modules set out above, and
5. the development of a learning plan in collaboration with the Expert;

vi. Within 30 days after the Member has completed the last session, the Member will confirm that the Expert forwards his/her report to the Director, in which the Expert will confirm:

1. the dates the Member attended the sessions,
2. that the Expert received the required documents from the Member,
3. that the Expert reviewed the required documents and subjects with the Member, and
4. the Expert's assessment of the Member's insight into her behaviour;

vii. If the Member does not comply with any one or more of the requirements above, the Expert may cancel any session scheduled, even if that results in the Member breaching a term, condition or limitation on her certificate of registration;

b) For a period of 12 months from the date this Order becomes final during which the member is engaged continuously in the practice of nursing (i.e. not including the period during which the Member's certificate of registration is suspended), the Member will notify her employers of the decision. To comply, the Member is required to:

i. Ensure that the Director is notified of the name, address, and telephone number of all employer(s) within 14 days of commencing or resuming employment in any nursing position;

ii. Provide her employer(s) with a copy of:

1. the Panel's Order,
2. the Notice of Hearing,
3. the Agreed Statement of Facts,
4. this Joint Submission on Order, and
5. a copy of the Panel's Decision and Reasons, once available;

iii. Ensure that within 14 days of the commencement or resumption of the Member's employment in any nursing position, the employer(s) forward(s) a report to the Director, in which it will confirm:

1. that they received a copy of the required documents, and
2. that they agree to notify the Director immediately upon receipt of any information that the Member has breached the standards of practice of the profession.

4. All documents delivered by the Member to the CNO, the Expert or the employer(s) will be delivered by verifiable method, the proof of which the Member will retain.

Penalty Submissions

Submissions were made by College Counsel.

The aggravating factors in this case were:

- The Member's conduct was serious;
- The Member's conduct posed a risk of harm to the patient;
- There was a disregard of professional obligations;
- The Member demonstrated poor judgement.

The mitigating factors in this case were:

- This was a single incident of misconduct;
- The Member has no prior history with the College;
- The Member has agreed to cooperate with the College;

- The Member has admitted and accepted responsibility.

The proposed penalty provides for general deterrence through an oral reprimand and a two-month suspension. This sends a clear message to the profession that the failure to meet one's professional obligations can result in serious disciplinary sanctions. Furthermore, the terms, conditions and limitations on the Member's certificate indicate to the membership, and the public, that this type of behaviour is taken seriously by the College and by this Discipline Committee. It also sends a strong message that this is a profession that is capable of governing itself.

The proposed penalty provides for specific deterrence through the two-month suspension. As well, the oral reprimand will assist the Member in gaining a greater understanding of how her actions are perceived by both the profession and the public. The terms, conditions and limitations will provide monitoring of the Member's practice and conduct.

The proposed penalty provides for remediation and rehabilitation through the two meetings with the Nursing Expert, the review of the College's publications and the completion of the reflective questionnaires and on-line participation forms. These requirements will help deepen the Member's understanding of her misconduct and will help to ensure that this conduct is not repeated.

Overall, the public is protected because this process will assist the Member in gaining additional insight and knowledge into her practice. This will inform her practice in the future. The 12-month employer notification will ensure that the Member's practice is monitored for a significant time when she returns to nursing after the suspension.

College Counsel submitted three cases to the Panel to demonstrate that the proposed penalty fell within the range of similar cases from this Discipline Committee.

CNO v. Thompson (Discipline Committee, 2019). This was an uncontested hearing. The member engaged in non-therapeutic communication, used excessive force pinning and holding a patient down while trying to restrain the patient. This conduct was found by the panel to be disgraceful, dishonourable and unprofessional. This conduct is more serious in nature compared to the above Member's however it is similar to the Member having restrained a patient. The penalty was for an oral reprimand, a six-month suspension, two meetings with the Nursing Expert and an 18-month employer notification.

CNO v. Blum (Discipline Committee, 2019). This was an uncontested hearing. There were two clients involved in the hearing. For Client A the member failed to observe the client in a locked room while self-harming behaviour (head banging) occurred. The member failed to de-escalate the patient's behaviour and once a chemical restraint was administered the member failed to continually assess the patient. In regards to Client B, the member swatted or slapped the patient's hand and used words to the effect of "stop pawing me, don't hit me or I won't help you". The penalty was for an oral reprimand, a three-month suspension, two meetings with the Nursing Expert and a 12-month employer notification.

CNO v. Unger (Discipline Committee, 2017). This was an uncontested hearing. This case is similar to the above matter. The member pushed a client into the wall, holding the patient's wrist, forcing the client into a chair, immobilized the client for approximately 30 seconds. There was no clinical basis to

complete that act. The member failed to document the interaction with the client or need to restrain the client. The penalty was for an oral reprimand, a two-month suspension, two meetings with a Nursing Expert and an 18-month employer notification.

The Member's Counsel made submissions. It was the Member's position that the Panel should accept the Joint Submission on Order. The Joint Submission on Order has four components, a reprimand and suspension of two months, a minimum of two meetings with the Nursing Expert and a 12-month employer notification. This penalty is appropriate, reasonable and in the public interest. It considers the mitigating and aggravating factors in this case. The penalty meets the goal of specific and general deterrence as well as remediation and rehabilitation and is consistent with other cases.

The Member's Counsel reviewed with the Panel the case of *Regina v. Anthony-Cook* and submitted that the Joint Submission on Order is not contrary to the public interest given the aggravating and mitigating factors and prior discipline decisions. There are numerous mitigating factors that have been recognized.

The Member is an experienced nurse with sixteen years in the profession. This is her first offence and it is the first matter that was ever brought to the College. The evidence in the Agreed Statement of Facts supports that the patient was at a high risk for falls, unstable and uncooperative, placing her at risk. The patient's interest was also front and centre in the Member's mind when implementing the restraint. The Member's intention was not to harm the patient and there was no evidence that the patient was harmed in this case. The patient was left in the restraint due to an error in the implementation of instructions. The Member has cooperated with the College throughout the process and took accountability for her actions as demonstrated through the Agreed Statement of Facts and Joint Submission on Order. The Member has participated in the hearing. The mitigating factors weigh in favour of accepting the Joint Submission on Order.

Penalty Decision

The Panel accepts the Joint Submission on Order and accordingly orders:

1. The Member is required to appear before the Panel to be reprimanded within three months of the date that this Order becomes final.

2. The Executive Director is directed to suspend the Member's certificate of registration for two months. This two-month suspension shall take effect from August 10, 2020 and shall continue to run without interruption as long as the Member remains in the practising class.

3. The Executive Director is directed to impose the following terms, conditions and limitations on the Member's certificate of registration:

    a) The Member will attend a minimum of two meetings with a Regulatory Expert (the "Expert") at her own expense and within six months from the date that this Order becomes final. If the Expert determines that a greater number of session are required, the Expert will advise the Director of Professional Conduct (the "Director") regarding the total number of sessions that are required and the length of time required to complete the additional sessions, but in any event, all sessions shall be completed within 12 months

from the date that this Order becomes final. To comply, the Member is required to ensure that:

i. The Expert has expertise in nursing regulation and has been approved by the Director of Professional Conduct (the "Director") in advance of the meetings;

ii. At least seven days before the first meeting, the Member provides the Expert with a copy of:

    1. the Panel's Order,
    2. the Notice of Hearing,
    3. the Agreed Statement of Facts,
    4. this Joint Submission on Order, and
    5. if available, a copy of the Panel's Decision and Reasons;

iii. Before the first meeting, the Member reviews the following CNO publications and completes the associated Reflective Questionnaires, online learning modules, decision tools and online participation forms (where applicable):

    1. *Professional Standards*,
    2. *Code of Conduct,*
    3. *Therapeutic Nurse-Patient Relationship,* and
    4. *Decisions about Procedure and Authority*;

iv. At least seven days before the first meeting, the Member provides the Expert with a copy of the completed Reflective Questionnaires and online participation forms;

v. The subject of the sessions with the Expert will include:

    1. the acts or omissions for which the Member was found to have committed professional misconduct,
    2. the potential consequences of the misconduct to the Member's patients, colleagues, profession and self,
    3. strategies for preventing the misconduct from recurring,
    4. the publications, questionnaires and modules set out above, and
    5. the development of a learning plan in collaboration with the Expert;

vi. Within 30 days after the Member has completed the last session, the Member will confirm that the Expert forwards his/her report to the Director, in which the Expert will confirm:

    1. the dates the Member attended the sessions,
    2. that the Expert received the required documents from the Member,
    3. that the Expert reviewed the required documents and subjects with the Member, and
    4. the Expert's assessment of the Member's insight into her behaviour;

vii. If the Member does not comply with any one or more of the requirements above, the Expert may cancel any session scheduled, even if that results in the Member breaching a term, condition or limitation on her certificate of registration;

b) For a period of 12 months from the date this Order becomes final during which the member is engaged continuously in the practice of nursing (i.e. not including the period during which the Member's certificate of registration is suspended), the Member will notify her employers of the decision. To comply, the Member is required to:

i. Ensure that the Director is notified of the name, address, and telephone number of all employer(s) within 14 days of commencing or resuming employment in any nursing position;

ii. Provide her employer(s) with a copy of:

1. the Panel's Order,
2. the Notice of Hearing,
3. the Agreed Statement of Facts,
4. this Joint Submission on Order, and
5. a copy of the Panel's Decision and Reasons, once available;

iii. Ensure that within 14 days of the commencement or resumption of the Member's employment in any nursing position, the employer(s) forward(s) a report to the Director, in which it will confirm:

1. that they received a copy of the required documents, and
2. that they agree to notify the Director immediately upon receipt of any information that the Member has breached the standards of practice of the profession.

4. All documents delivered by the Member to the CNO, the Expert or the employer(s) will be delivered by verifiable method, the proof of which the Member will retain.

Reasons for Penalty Decision

The Panel understands that the penalty ordered should protect the public and enhance public confidence in the ability of the College to regulate nurses. This is achieved through a penalty that addresses specific deterrence, general deterrence and, where appropriate, rehabilitation and remediation. The Panel also considered the penalty in light of the principle that joint submissions should not be interfered with lightly.

The Panel concluded that the proposed penalty is reasonable and in the public interest. The Member has co-operated with the College and, by agreeing to the facts and a proposed penalty, has accepted responsibility. The Panel finds that the penalty satisfies the principles of specific and general deterrence, rehabilitation and remediation, and public protection.

The penalty is in line with what has been ordered in previous cases.

I, David Edwards, RPN sign this decision and reasons for the decision as Chairperson of this Discipline panel and on behalf of the members of the Discipline panel.